Lower Loudoun Little League Medical Release

Players Full Name: _____ **Date of Birth:** _____

League Name: _____ (Example: National AA-Rockies)

PARENT OR GUARDIAN AUTHORIZATION:

In case of emergency, if family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel (i.e. EMT, First Responder, and E.R. Physician).

Family Physician: _____ **Phone:** _____

Address: _____

Insurance Company: _____ **Insurance #** _____

Hospital Preference: _____

In Case of emergency, contact:

Name _____ **Phone** _____ **Relationship to Player**_____

Name _____ **Phone** _____ **Relationship to player**_____

Please list any allergies/medical problems, including those requiring maintenance medication.
(i.e. Diabetic, Asthma, Seizure Disorder)

Medical Diagnosis	Medication	Dosage	Frequency of dosage

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem that may interfere with or alter treatment.

Date of last Tetanus Toxoid Booster: _____

Mr./Mrs./ Ms. _____
(Authorized Parent/Guardian Signature)

Mail completed form to:
Lower Loudoun Little League
P. O. Box 23
Sterling, Virginia 20167